MINUTES

eHealth Care Quality and Patient Safety Board

Information Exchange Workgroup

September 21, 2006

Location: GE HealthCare Research Park Facility, 9900 Innovation Drive, Wauwatosa, WI 53226

Time: 10:00 a.m. - 4:00 p.m.

Attendees:

Members

- Denise Webb
- Louise Wenzlow
- Hugh Zettel (Chair)

Resources

- Keith Haugrud
- Terry Hiltz
- Deb Rislow

Staff

- Stacia Jankowski
- Susan Wood

Approval of meeting minutes

The minutes of September 14 were approved as written.

Review of results from scoring tool

Louis Wenzlow said part of the difficulty in scoring these requirements, is not knowing what really is feasible. He suggested that five to ten Regional Health Information Organizations (RHIOs) that have implemented electronic health information exchange, and ask them to score each of these items. This would more clearly identify the business needs. Hugh Zettel reported that eHI's third annual report is due out soon, which could provide some benchmarks that could assist in confirming the information recorded by the group.

Assumptions

- At the statewide exchange level, assuming that the person logging on has been authenticated at the local level.
- Wisconsin will align with the standards being developed at the national level.

Recommendations:

- There was discussion of ensuring the authentication and authorization and the need to ensure that the "edge systems" have the proper auditing and exchange. The recommendation was to require a certain level of auditing should at the local level before allowing the organizations to be included in the exchange.
- The workgroup members discussed options for creating an architecture that meets the needs of the regions and is timely. The recommendation was to promote a centralized model at the regional level and a federated model at the state level.

This model will allow the regions to centralize records, if necessary, in order to ensure that records can be retrieved in a timely manner, but also allowing for exchanges without needing to search hundreds of databases.

- Examine how security is addressed in other states.
- Security will be focused at the local level. The workgroup discussed the concept of having the most stringent security being imposed upon all agencies. Due to the barrier this could impose on small organizations, the group decided to examine how this is addressed in other states, but with the assumption that the current HIPAA requirements would be the minimum security level.
- Due to the moving target of health care technology for exchange, needs to be flexible, adaptable, and replicable. As part of this effort, the workgroup discussed the idea of open standards, so that the programs are interoperable. These standards could be driven at the national level, but if there is a need, these standards should be addressed at the state level.

Mr. Wenzlow noted that there may not be the resources to support these efforts at the local level. Some large hospitals may be able to integrate all of these functions into their systems, but many small providers may be left out of the exchange. Due to these concerns, the workgroup recommended that the Financing Workgroup conduct analysis on possible tax breaks and incentives to ensure that the small providers are not forced out of the exchange.

Attendees:

Members

- Ed Barthell (Chair)
- Lowell Keppel

Resources

- Dana Richardson

Staff

- Seth Foldy

Patient Care Workgroup Minutes

The Patient Care Workgroup minutes were approved as written.

Guiding principles

The workgroups spent a little time reviewing some of the recommendations that were made by the Information Exchange Workgroup earlier in the meeting.

The Patient Care Workgroup members reviewed their concerns regarding the current draft of the guiding principles. The workgroups revised the language relating to the phasing of these efforts to more closely align with the Patient Care Workgroups priorities. Mr. Zettel clarified that Phase 1 does not need to be completed before Phase 2 begins.

Mr. Zettel was going to take a first cut at revising Phase 3 and 4 to be clearer, as the workgroup members thought that this language was not very clear. In particular, the members were not clear about what was meant by "access control."

Through the discussions about the phasing of these efforts, the workgroups made the recommendation that careful consideration be given to redesigning enforcement for special protection data, such as mental health, HIV testing, etc.

In addition, the workgroup members discussed the option of patient access to update their records. The discussion included the issue of liability and the best method for incorporating this information into the record. The consensus was that this should be incorporated in spite of the liability issue, but that a method for "flagging" this information should be identified to address the issue.

Use Case Scenarios

Ed Barthell said that the use case scenarios were designed from the American Health Information Community (AHIC) Harmonized Use Case Scenarios, but modified to more closely align with Wisconsin's needs. He provided a document that more clearly laid out the process that was envisioned for each. Stacia Jankowski will be incorporating flow diagrams into these documents using the AHIC use cases as a model.

Recommendation: Adapt the structure of the view to incorporate a metadata structure. This will allow export and import functionality in a similar way. This will be incorporated into the Medicaid Transformation Grant proposal.

A few efforts that impact the priorities related to implementation include:

- National effort to implement e-prescribing as part of Medicare Part D, with full implementation to occur by 2009(?). E-prescribing should be pulled into the exchange as soon as it made available through this effort.
- The incorporation of a metadata structure to Wisconsin Medicaid data through the inclusion in the Medicaid Transformation Grant.
- National standards under development, such as HITSP.

The workgroup members discussed decision support. There was discussion about whether this should occur at a regional or state level. The argument for having this at the state level was efficiency, although there was concern that adoption of this system would differ based on the organizations and is extremely complex technologically. The workgroup members discussed the need for public health guidance to be done at the state level, but recognized the richness of the data in the home system and therefore would advocate for local decision support. The workgroup members recognized the need for extensive patient

and provider education with the implementation of a decision support system. Mr. Zettel offered to follow-up on the material coming out of AHIC regarding this.

Further assumptions reached included:

- The data being accessed in the exchange is relatively "clean."
- Methods and policies are in place for correcting inaccurate data.
- To ensure validity/integrity of the data in the exchange, standards will be developed to address issues such as duplication.